BOSTON IVF

GENETIC SCREENING CONSENT

This is a special consent form for genetic testing. Please read it carefully. If you do not understand something in this consent form or in the information you have received about recommended genetic testing please ask for additional information before you sign this form.

1. **Purpose:** I understand the purpose of the testing to determine if I am a carrier of one or more genetic disorders. A carrier has a change in a specific gene or genes that increases his or her chance of having a child with a genetic disorder or birth defect. A list of all of the disorders being screening for and a general description of each disorder can be provided.

2. **Methods:** Testing is performed on a small sample of blood. Accurate information about my family history and ethnic background is required for an accurate interpretation of the test results.

3. **Results:** I understand that if the test results are **positive** I am a carrier of the disorder tested. I may also learn that I have an undiagnosed disorder, that I carry mutations in multiple genes or that I am at increased risk for a different disorder caused by mutations in one of the genes tested. The genetics laboratory does not report all DNA changes that could be disease causing. If the test result is **negative**, my risk of being a carrier or having the disorder tested, is reduced but not eliminated.

4. **Risks and limitations:** I understand that the test results may not provide **definitive** conclusions regarding reproductive risk. While this testing is highly accurate, rare testing errors may occur. Further testing may be warranted for myself or my partner and this additional testing may or may not be covered by insurance. Accurate results may not be obtained for reasons including but not limited to sample mix-up, bone marrow transplant, recent blood transfusion, or technical problems. Sometimes for technical reasons, results cannot be generated. Additional samples may be needed if results are not generated.

5. **Testing of additional family members** may be requested which could discover previously unknown information about family relationships, such as non-paternity (someone who is not the biological father), or adoption.

6. **Re-contact:** I understand that the genetic laboratory does not have a responsibility to re-contact me in the future when new tests are added to their menu, or when additional DNA mutations are added to the tests offered.

7. **Result disclosure:** The test results will be contained in my medical record and Boston IVF will take all appropriate safeguards to protect the confidentiality of my personal health information. However, I hereby consent to the release of these results to my partner (if applicable), the physicians and staff directly involved in my care for the purpose of my treatment, my current insurance carrier in order to seek coverage or reimbursement, and others specifically authorized by law to gain access to my medical records.

8. **Genetic Counseling:** I have been informed about the importance of genetic counseling and its availability both prior to and after testing. I have received written information identifying a genetic counselor from whom I might obtain such counseling.

9. **Cost:** Many insurance plans pay for the testing. However, the cost of this test may not be covered by your insurance and you would be responsible for the costs associated with the genetic test.

My signature below indicates that I have read, or had read to me, and understand the above information. The decision to consent to, or to refuse, the above testing is entirely mine. I have all the information I want, and all my questions have been answered to my satisfaction.

☐ **YES**, I give consent for carrier testing. ☐ **NO**, I do **not** give consent for carrier testing.

_____ _____

Print name of patient Patient's signature

_____

Patient date of birth

_____

Today's date